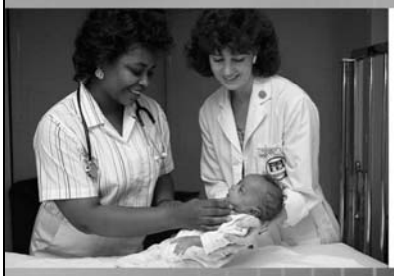
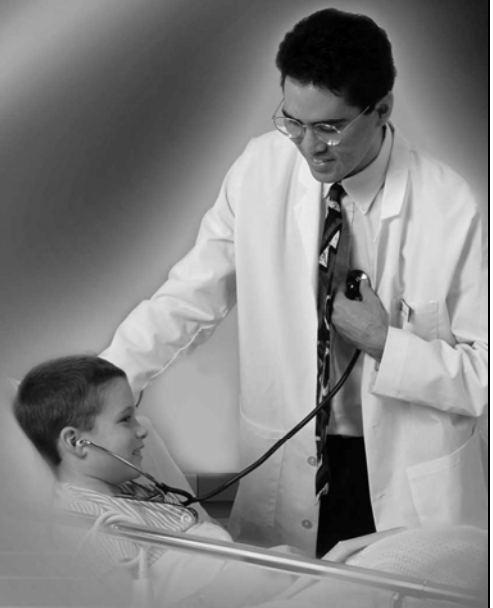
Task Force on Culturally & Linguistically Competent Physicians and Dentists



Final Report to the Legislature Pursuant to AB 2394

Chapter 802, Statutes of 2000



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TASK FORCE ON CULTURALLY AND LINGUISTICALLY COMPETENT

PHYSICIANS AND DENTISTS

FINAL REPORT TO THE LEGISLATURE

In 2000, Governor Davis signed Assembly Bill 2394 (Chapter 802, Statutes of 2000) by Assembly Member Marco Firebaugh, that established the Task Force on Culturally and Linguistically Competent Physicians and Dentists (Task Force), co-chaired by the Director of the Department of Consumer Affairs, Kathleen Hamilton, and the Director of the Department of Health Services, Diana Bontá. *A copy of AB 2394 is included in Appendix A.*

In their approval of AB 2394, the Legislature and the Governor have acknowledged the need for California's health care delivery system to evolve in order to meet the needs of California's diverse populations. According to data provided by the Department of Finance drawn from the 2000 U.S. Census, more than 34 million people live in California. Of that population, approximately 47% are White, 6% are Black, .5% are Native American, 11% are Asian and Pacific Islander, and 33% are Hispanic, 2.5% fall into a category, "other race, Non-Hispanic". Additionally, 26% of the population is foreign-born and 40% reported speaking a language other than English at home.

Many consumers in these communities find that physicians, dentists, and allied health professionals cannot understand their health care needs because they cannot communicate with consumers in their native language. Non-English speaking consumers face linguistic barriers from the time they schedule an appointment, see the provider for direct services, follow treatment directions, and in many cases, receive a pharmacist consultation and understand dosage instructions for pharmaceuticals. Without health care providers who are competent in languages other than English at each of these points of entry in the health care system, consumers who do not speak English may receive sub-standard care.

Adding to this complexity are the diverse cultural beliefs that many consumers bring to discussions and decisions about their health care. Health care providers also bring their own racial biases or prejudices to their encounters with patients, adding to the complexity of the interaction. Culture is understood as the perspective each of us uses to interpret our day-to-day experiences, based on the environment in which we were raised, our values, individual preferences, and group norms. Naturally, our cultural beliefs impact and shape our beliefs about health care and the health care delivery system. Because health care providers frequently do not understand unique cultural beliefs about health care that many consumers hold, and may not consider culture when developing a treatment plan, consumers may be given treatment regimens they will not follow. As a result, it is more important than ever that health care providers bring a degree of cultural competency to interactions with their patients. Although there is no

common definition of culture or agreement on how to measure cultural competency, there is widespread agreement that increased cultural competency would improve health care in California.

Recognizing these challenges and the critical need to ensure that all Californians receive health care in a manner that is culturally and linguistically appropriate, the Legislature established the Task Force to explore innovative ways to improve the health care delivery system and to ensure that all Californians receive health care that is delivered in a culturally sensitive manner and in a language that they understand.

Specifically, AB 2394 required the Task Force to:

- **Develop recommendations for a continuing education program that includes language proficiency standards of foreign language to be acquired to meet linguistic competency.**

- **Identify the key cultural elements necessary to meet cultural competency by physicians, dentists, and their offices.**

- **Assess the need for voluntary certification standards and examinations for cultural and linguistic competency.**

- **Hold hearings to obtain input from persons belonging to language and ethnic minority groups to determine their needs and preferences for having culturally competent medical providers.**

- **Report its findings to the Legislature and appropriate licensing boards within two years after creation of the Task Force.**

The Task Force was convened on March 8, 2001 and began to tackle these complex directives from the Legislature. Recognizing the wealth of expertise that exists in California on this topic, the Task Force began to seek input from community providers, consumers, academics, physicians and dentists, representatives from community clinics, and other interested parties. The Task Force was given two years to do this work prior to submitting this final report to the Legislature. While the Task Force made much progress, the extensive nature of these issues and their complexity lend themselves to ongoing study and discussion.

APPOINTMENT OF THIRTY-SEVEN MEMBERS TO THE TASK FORCE

AB 2394 specified the composition of the Task Force. The Task Force was comprised of 37 members, including representatives from state government and state licensing boards, community clinics, consumer advocacy groups, representatives of immigrant, Latino, and Asian communities, and other key

stakeholders. *A complete roster of Task Force members is included in Appendix B.*

SUBCOMMITTEE OF THE TASK FORCE

Assembly Bill 2394 also created a Subcommittee of the Task Force, to be chaired by the Director of the Department of Health Services, Diana Bontá. AB 2394 charged the Subcommittee with "*examining the feasibility of establishing a pilot program that would allow Mexican and Caribbean licensed physicians and dentists to practice in nonprofit community health centers in California's medically underserved areas.*" The Subcommittee was required to submit a report to the Legislature on April 1, 2001. Pursuant to this mandate, the Task Force's Subcommittee submitted its report to the Legislature in July 2001. *That report is included in its entirety as Appendix C.*

As mandated by the statute, the composition of the Subcommittee consisted of: the Director of the Department of Health Services (Chair), the Executive Director of the Medical Board of California, the Executive Officer of the Dental Board of California, and the Director of the Office of Statewide Health Planning and Development. Additionally, Director Bontá appointed additional members to the Subcommittee who met criteria outlined in the statute.

Those criteria included:

- **Representatives of organizations that advocate on behalf of California licensed physicians and dentists.**

- **A representative of a nonprofit clinic association that advocates on behalf of members of language and ethnic minority groups and provides health services to a patient population that meets specified characteristics.**

The Subcommittee held meetings in Sacramento to solicit comment from interested parties on the feasibility of establishing a pilot project for physicians and dentists from Mexico and the Caribbean to practice in medically underserved communities in California.

During the course of the Subcommittee's work, proposals were submitted by the California Dental Association, the California Medical Association, the Medical Board of California, the California Hispanic Health Care Association, the California Latino Medical Association, the Latino Coalition for a Healthy California, and Dr. Maximiliano Cuevas to be forwarded to the Legislature as required by AB 2394. The Subcommittee discussed each proposal at length and attempted to identify either a proposal or elements of a proposal upon which the Subcommittee could reach consensus for the purpose of making recommendations to the Legislature. To facilitate the discussion, the

Subcommittee Chair directed staff to prepare a matrix outlining the key aspects of each proposal.

While there was agreement in several areas proposed, the Subcommittee did not achieve consensus on the following key issues:

- **Should licenses provided to physicians coming from Mexico and the Caribbean under a pilot project be permanent or temporary?**

- **What health care delivery settings should project participants be placed in?**

- **The means of assuring cultural and linguistic competency of participants.**

- **The time span to implement the pilot project (short-term, one-two years versus longer-term).**

- **Licensing and professional residency requirements for participants.**

Because there was no consensus on the feasibility and components of a pilot project, all the original proposals submitted to the Subcommittee were included in the Subcommittee's report to the Legislature, along with a discussion of the Subcommittee's work and the areas of disagreement. Although the Subcommittee's report does not endorse any specific pilot program, it outlines options that may be considered by the Legislature to expand the availability of providers in medically underserved areas.

PUBLIC HEARINGS

Assembly Bill 2394, mandated that the Task Force ***"hold hearings and convene meetings to obtain input from persons belonging to language and ethnic minority groups to determine their needs and preferences for having culturally competent medical providers. These hearings and meetings shall be convened in communities that have large populations of language and ethnic minority groups."***

To meet this statutory mandate, the Task Force held a series of public hearings throughout the State. These public hearings established a forum for members of the community to share their experiences as health care consumers and providers regarding language or cultural barriers in the delivery of health care. Task Force members had the opportunity to hear directly from members of the public whose lives will be most directly impacted by the recommendations made to the Legislature in the Task Force's final report in 2003.

The Task Force heard from many practicing physicians and dentists about the need to be conversant in languages other than English and to be familiar with other cultural beliefs in order to provide high-quality care. These providers also shared many of the creative strategies they have implemented in order to better serve their patients. The Task Force also heard from hospital systems and community clinics that have implemented in-house training programs to better enable their staff to communicate with their diverse patient populations.

Extensive testimony was given by individuals who have been licensed and practiced in other countries and are now living in the United States, but no longer working in health care related professions. These professionals indicated a strong desire to use their skills in California's health care system, but were unable to meet state licensing requirements primarily due to educational requirements. Many of these professionals are currently pursuing state licensure as physicians or dentists, and others are working or seeking licensure in allied health fields. The number of these professionals who spoke at the public hearings is evidence of the need to explore ways to bring them into the health care delivery system, particularly in light of the many professional shortages that currently exist.

Additionally, the Task Force heard testimony from non-English speaking consumers who testified about the difficulty of receiving care from providers that do not speak or understand the consumer's language or culture. They spoke about their discomfort using their children as interpreters, their frustration at efforts to have their providers understand them, and in some cases, the adverse consequences they have experienced as a result of avoiding health care services altogether as a result of these challenges. All of them spoke eloquently about their desire to be treated with respect by health care providers and their staff and the discomforting reality that they were often not treated that way.

The public hearings were a vital component of the Task Force's work. They clearly confirmed the need to enhance cultural and linguistic literacy in the delivery of health care and they inspired consideration of innovative solutions.

WORKING GROUPS

AB 2394 charged the Task Force with developing recommendations for a continuing education program that includes language proficiency standards to be acquired to meet linguistic competency, identifying key cultural elements necessary to meet cultural competency for physicians, dentists, and staff, and assessing the need for voluntary certification standards and examination for cultural and linguistic competency.

In order to complete these tasks with a large number of members in a short time frame, the Task Force initially established three working groups. These working groups were focused on key elements of cultural competency, continuing

education, and voluntary cultural competency certification. To minimize duplication of efforts, the continuing education and voluntary cultural competency certification groups were ultimately combined.

The working groups allowed for in-depth discussion between a smaller number of Task Force members. The working groups held public meetings in both Southern and Northern California, where they heard testimony on the specific matters before the working groups. With the participation of providers and others working in the field, the working groups also engaged in detailed discussion of how proposed recommendations could be implemented. The working groups ultimately forwarded their recommendations to the full Task Force.

WORKING GROUP ON CULTURAL COMPETENCY STANDARDS

The Department of Health Services administered this working group which met regularly in both Southern and Northern California in 2001 and 2002. The working group was co-chaired by Task Force members Doreena Wong and Miya Iwataki. Discussions centered on what was desirable as a "standard" versus what could be reasonably implemented by providers at various levels. The group's final report presented their proposed key cultural elements, with an accompanying narrative to be used to develop standards. In addition to developing an extensive list of recommendations, the group also developed a number of resource materials including a glossary of key terms, a list of relevant laws, policies and accreditation requirements, and a directory of state and private organizations that assist patients with complaints. *A copy of the report the working group forwarded to the Task Force is included in Appendix D.*

WORKING GROUP ON CONTINUING EDUCATION AND CULTURAL COMPETENCY CERTIFICATION

The Department of Consumer Affairs administered this working group which met throughout 2001 and 2002 in both Southern and Northern California. The working group was chaired by Ron Joseph, Executive Officer of the Medical Board of California. Much of the working group's debate centered on the issue of mandatory vs. voluntary continuing education and certification for licensed physicians and dentists. The working group did not recommend mandatory continuing education and certification, but decided that the acquisition of additional language and cultural education skills should be up to the individual professional. This issue of mandatory vs. voluntary continuing education and certification for physicians, dentists, and other allied health professionals generated significant debate within the Task Force as a whole. *A copy of the recommendations that the working group forwarded to the Task Force are included in Appendix E.*

UCSF STUDY

Throughout discussions of how to increase the number of physicians and dentists practicing in California that are culturally and linguistically competent, the issue of medical and dental education continued to emerge as a key policy area. Recognizing the potential of a "pipeline" approach, in which newly licensed physicians and dentists might possess knowledge, skills, and abilities that make them culturally and linguistically competent when they enter their practice, much discussion was focused on expanding the cultural and linguistic education and training that is provided in medical and dental schools. The Task Force found that prior to making recommendations about changing the content of medical and dental education, more information was needed on what is currently taught in the way of cultural and linguistic competency education.

The Task Force contracted with the University of California at San Francisco (UCSF) to examine what courses and experiences directed toward increasing cultural and linguistic competence are provided by California medical and dental schools and what is the content of these courses. The study found that medical and dental schools have a large number of hours spent on teaching cultural competence, when measured to include both didactic and clinical and group courses. The content of the cultural competence teaching is quite varied, but more depth should be emphasized, especially in the practical area of content. The study found that current ethnic diversity of faculty, students, and community clinic experiences seem to contribute to the teaching of cultural competence in these schools. As the curriculums change over time, vigilance is needed to ensure that there is continued teaching in cultural competence and that current talent in this area at the universities is used to enrich the medical and dental school curriculum.

While Task Force members found the results of the UCSF study to be informative, the conclusion was that more study was needed. Some Task Force members expressed concern that the UCSF study reflects that the UC system is very diverse and questioned that premise given changes to affirmative action policies in recent years. Members also commented that the study relied too heavily on the feedback of students and not enough from faculty. Even with these concerns, the UCSF study did provide the Task Force members with the opportunity to discuss how medical and dental schools may better prepare their students to provide culturally and linguistically competent physicians and dentists.

A full report of the UCSF study is included in Appendix F.

RESOURCE INFORMATION AND MATERIALS

As part of the Task Force's solicitation of information and expertise on these topics, voluminous resource materials were provided to the Department of Consumer Affairs. These materials were provided to Task Force members and in a number of instances, subject matter experts were invited to present their research to the Task Force. *A complete list of subject matter experts who made presentations to the Task Force is included in Appendix G.*

These resources provided valuable background information to the Task Force members in understanding work already undertaken in various communities to ensure the provision of culturally and linguistically competent health care. This research provided the Task Force with background, historical information, and a context for future planning. *Included in Appendix H is a bibliography of the materials that were collected by the Task Force to inform discussion and recommendations.*

FINAL RECOMMENDATIONS

Many recommendations came to the full Task Force from discussions that were held at the working groups and the public hearings. These recommendations, with a notation on where they were generated from, are presented below.

RECOMMENDATIONS ADOPTED BY THE TASK FORCE

- Recommended that the University of California (UC) report to the Legislature on initiatives that are underway and could be developed to address the shortcomings, limitations, and structural impediments identified in the UCSF study conducted for the Task Force.

- Recommended that medical and dental schools and the University of California (UC) report to the Legislature on initiatives that are underway and could be developed to address the shortcomings, limitations, and structural impediments identified in the UCSF study conducted for the Task Force.

- Recommended that the Department of Consumer Affairs, including the Medical and Dental Licensure Boards, and the Department of Health Services, including the Office of Multi-Cultural Health, continue the oversight and administration of the development and implementation of the proposed recommendations, working with the Task Force or another representative body that includes providers, consumers, advocates, and individuals with knowledge and experience in addressing cultural and linguistic issues.

Recommendations presented from the Working Group on Continuing Education and Cultural Competency Certification.

- Recommended the development of a continuing education program that leads to linguistic competency, which enables the health care provider to communicate effectively with clients and patients who speak that particular language and that is based on the literacy level of non-English speaking populations to be served.

- Recommended the development of a continuing education program that leads to cultural competency, which enables the health care provider to interact effectively with clients and patients from different cultural backgrounds.

- Recommended that the Dental Board and the Medical Board be required to accept approved linguistic and cultural courses as meeting the existing requirements for continuing education and promote availability of such courses to encourage their utilization by practitioners with the goal of ensuring cultural and linguistic competency by practitioners.

- Recommended that the Dental Board and the Medical Board monitor, for the two years following enactment, attendance by providers at approved linguistic and cultural competence continuing education courses and report these findings to the Legislature.

- Recommended the development of incentive-based models to include consideration of reimbursement enhancements and other awards that encourage providers to achieve cultural and linguistic competency and include contract and reimbursement incentives. The public and private sectors should establish criteria for acknowledging model programs that foster the development of cultural and linguistic competency.

Recommendations presented from the Working Group on Cultural Competency Standards

- California needs to identify and promote the current and ongoing standards for cultural and linguistic competency by a nationally recognized body or effort. The Task Force recommends the adoption of the Office of Minority Health of the U.S. Department of Health and Human Services' "Final Report on National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care, released March 2001, available at: www.omhrc.gov/clas. We would also recommend that the Department of Consumer Affairs, the Department of Health Services, and other state departments and agencies examine ways in which they could implement the CLAS standards on a statewide level and take appropriate action to do so.

- In terms of state financial support for the development of cultural and linguistic standards, we recommend that California explore various sources of private funding, such as The California Endowment and other funders who are underwriting local, state, and national initiatives. At a minimum, the state should support such efforts to the extent possible.

- Recommended the establishment of a new task force or the continuation of the current task force to further develop, implement, and oversee any proposed recommendations received and adopted by the current task force and/or any action items which result from additional recommendations of the new task force.

- Recommended exploring and pursuing the development of a California exam for cultural and language proficiency for licensed providers, including physicians and dentists, who meet the cultural and linguistic requirements to ensure competency. This exam would be voluntary and based on an incentive approach.

- Recommended that the state develop a uniform system of data collection relative to race, ethnicity, and primary language data and encourage its use by all health care providers and organizations.

- Recommended that medical and dental schools develop a standard curriculum for medical and dental students that would enhance cultural competency to ensure appropriate delivery of services and practices.

Recommendations Presented At The Public Hearings

- In addition to loan forgiveness programs, develop scholarship and incentive programs for students who are pursuing or considering careers in medicine that include recognition of outstanding achievements and certificates of appreciation and not primarily monetary incentives.

- Dental programs are allowing graduates to complete an additional year in a general practice residency to allow students to have more exposure to clinical procedures. In addition, New York has started a similar program where the additional year served in the general practice residency is in lieu of taking the practical examination for licensure. Some of these residencies are done in medically underserved areas. These models should be considered for replication in California.

- Explore the Stanford Medical School public service curriculum where the medical school education is five years instead of the customary four. Students voluntarily work at community health centers or other low-income community settings for part of their fifth year.

- Medical schools should encourage three months of rotation in community service within the first internship year or the fourth year prior to receiving the medical license. This would be more amenable in the medical context to capturing graduates prior to them diverging into their various subspecialties and encouraging them to develop family practice skills and work in communities where they can develop cultural and linguistic skills.

- Increase the number of hours within dental education where students serve in community based clinics.

- Encourage physicians and dentists to use allied health professionals, such as nurses, nurse practitioners, and physician assistants in their practice settings to increase the number of providers who are culturally and linguistically competent.

- Develop mechanisms to match qualified international medical graduates (IMGs) and US medical graduates (MGs) to the areas of need. Provide assistance to IMGs in obtaining a medical license or other career opportunities in the health care delivery system.

- Restore the Fifth Pathway Program to bring physicians educated in Mexico to California to practice.

CONCLUSION

The Task Force, through the contributions of the expert members, interested parties, providers, and consumers who offered testimony at the meetings and public hearings, heard and evaluated many perspectives prior to developing its final recommendations. The final recommendations are the product of many hours of informed debate and discussion. As this final report is submitted to the Legislature, the Task Force hopes that many of these recommendations will be implemented in order to improve the cultural and linguistic competency of health care providers and the quality of care provided to California's diverse patient populations.